AccuReview
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Notice of Independent Review Decision

[Date notice sent to all parties]: January 2, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

OP Lt Lateral Epicondyle Debridement, Lt Insitu Ulnar Nerve Release 24359

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

This physician is Board Certified in Orthopaedic Surgeon with over 15 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
08-05-14: Specialist Consultation Request at dictated by DO
08-21-14: Status Report: Follow-Up Evaluation at dictated by MD
08-21-14: Easy-Script at dictated by MD
08-22-14: Physical Therapy Evaluation at dictated by PT
08-22-14: Physical Therapy Daily Note at dictated by PT
08-25-14: MRI Examination of the Left Elbow at Imaging dictated by MD
08-28-14: Status Report: Follow-Up Evaluation at dictated by DO
08-28-14: Texas Workers' Compensation Work Status Report dictated by DO

09-03-14: Office Note at Orthopedic Therapy Institute dictated by OT
09-08-14: Status Report: Follow-Up Evaluation at dictated by MD
09-10-14: Physical Therapy Re-Evaluation at dictated by PT
09-10-14: Physical Therapy Daily Note at dictated by PT
09-11-14: Physical Therapy Daily Note at dictated by PT
09-15-14: Physical Therapy Daily Note at dictated by PT
09-16-14: Occupational Therapy Note at Orthopaedic LLP dictated by OT
09-17-14: Physical Therapy Daily Note at dictated by PT
09-19-14: Physical Therapy Daily Note at dictated by PT
09-19-14: Occupational Therapy Note at Orthopaedic LLP dictated by OT
09-22-14: Physical Therapy Daily Note at dictated by PT
09-26-14: Hand Therapy Re-Evaluation at Therapy Institute dictated by MD
09-26-14: Occupational Therapy Note at Orthopaedic LLP dictated by OT
09-30-14: Encounter and Procedures dictated by
10-02-14: Physical Therapy Re-Evaluation at dictated by PT
10-02-14: Physical Therapy Daily Note at dictated by PT
10-03-14: Physical Therapy Daily Note at dictated by PT
10-06-14: Physical Therapy Daily Note at dictated by PT
10-08-14: Physical Therapy Daily Note at dictated by PT
10-09-14: Physical Therapy Daily Note at dictated by PT
10-13-14: Physical Therapy Daily Note at dictated by PT
10-14-14: Status Report: Follow-Up Evaluation at dictated by MD
10-17-14: Occupational Therapy Note at Orthopaedic LLP dictated by OT
10-23-14: Office Visit: EMG and NCV dictated by MD
10-24-14: Hand Therapy Re-Evaluation at Therapy Institute dictated by MD
10-24-14: Clinical Encounter Summaries dictated by MD
10-24-14: Encounters and Procedures dictated by MD
10-28-14: Surgery Authorization Request: Lt Elbow dictated by MD
10-31-14: UR performed by MD
11-03-14: Appeal Surgery Authorization Request-Lt Elbow dictated by MD
11-04-14: Hand Therapy Re-Evaluation at Therapy Institute dictated by MD
12-03-14: UR performed by MD
12-05-14: Appeal Surgery Authorization Request-Lt Elbow dictated by MD

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a male whom was injured on the job on xx/xx/xx. The claimant was on a 6 foot ladder replacing a drain from the 2nd floor when he was tightening the drain and the ladder went from underneath him and he fell back onto both arms.

Specialist Consultation Request dictated by DO. Diagnosis: Bilateral sprain of neck 847.00, Left elbow arthropathy NEC-other arthropathy of elbow region 726.39, and right shoulder region-traumatic arthropathy 716.11. Test Results: MRI on left elbow w/o contrast: partial tear of common extensor tendon. Statement of medical necessity: the prescribed referral is deemed medically necessary.

08-21-14: Status Report: Follow-Up Evaluation dictated byMD. CC: right shoulder pain has subsided. He stated with movement, right thumb feels a pulling sensation up arm, 5/10 in shoulder, 6/10 left elbow, 3/10 in the neck. Numbness and tingling have remained in the left forearm. PE: Cervical spine: muscle spasm along the paraspinal muscle remained the same. Trapezius muscle spasm is noted right sided. Left elbow: Muscle testing pronation decreased. Diagnosis: bilateral sprain of neck 847.00, left elbow entesopathy NEC-other enthesopathy of elbow region 726.39, and right shoulder region – traumatic arthropathy 716.11. Recommendations: PT evaluation and treat on cervical spine, right shoulder, left elbow for essential functions, functional improvement, dynamic activities and HEP. Continue medication: naprosyn 500mg, Flexeril 10mg. MRI left elbow scheduled for 8/26. Begin PT. Advance restrictions. Continue meds.

08-22-14: Physical Therapy Evaluation dictated by PT. CC: pain at the right shoulder and left elbow and neck, stabbing, 3/10 at the right shoulder, left elbow 4-5/10 at rest with shooting pain into pinky finger. Test and Measures: Palpation/mobility testing: tenderness at the right anterior shoulder, posterior right shoulder over infraspinatus, left posterior elbow and lateral forearm. Assessment: Claimant presented with s/s consistent with neck strain, right shoulder contusion. Claimant has mild limitations at the right shoulder and left elbow/forearm. Question possible left elbow bruise that may ne aggravating ulnar nerve. Claimant will benefit from PT for restored ROM, strength and function at the neck, right shoulder and left elbow in order to return to all prior function. ADL Limitations: Overhead lifting or forceful work with right arm; lifting/carrying greater than 10# with left arm; forceful pushing/pulling; looking overhead. Functional Deficits: right shoulder pain, neck pain and left elbow pain with decreased ROM and functional strength at all areas. Job limitations: Overhead lifting or forceful work with right arm; lifting/carrying greater than 10# with left arm; forceful pushing/pulling; looking overhead.

08-25-14: MRI Examination of the Left Elbow dictated by MD. Impression: 1. Findings consistent with active lateral epicondylitis with partial thickness tearing of the common extensor tendon origin from the lateral humeral epicondyle.

08-28-14: Status Report: Follow-Up Evaluation dictated by DO. CC: Claimant stated his therapy was denied, s/s unchanged, pain 6/10 elbow and shoulder, and neck 1/10 when he turns to the right. PE: Cervical Spine: Muscle spasm along the paraspinal muscle decreased, trapezius muscle spasm right sided, tenderness to palpation decreased. Shoulder: Right: tenderness bicipital groove remained the same. Elbow: Left: muscle testing pronation decreased. Diagnosis: Left elbow enthesopathy NEC-Other enthesopathy of elbow region 726.39, Right shoulder region-Traumatic arthropathy 716.11. Recommendations: Continue PT, continue medications: naprosyn and Flexeril, Will hold PT on L elbow in light of the MRI findings, ortho eval for L elbow and referral to ortho for L elbow.

09-03-14: Office Note dictated by OT. CC: L elbow pain with use and movement, with mild to moderate episodes of paresthesias; no relief from one injection. Current level of function/ADL status: pain with difficulty in shuting door to truck; moderate difficulty with washing back, cutting food, donning shirt and opening tops and lids. Tries to avoid any lifting or carrying. AROM: elbow ext: R 0, L 0; elbow flex: R 135, L 128; Pronation/sup.: R & L WNL. Prov Test: Resisted WE +; Resisted LF none; Elbow Flexim +; Tinel's CT +. Palpation: pain over the origin of the ECRB & ECRL. Assessment: Claimant referred to with diagnosis L cubital tunnel & LE. He presented with elbow pain and episodes of paraesthesia on RF/SF. Prior to accident claimant was WNL. Current deficits are limiting his ability to use the LUE of advanced ADL's and WNL related tasks. HE will benefit from skilled OT to help promote streaking.

09-16-14: Occupational Therapy Note dictated by OT. CC: arm pain continued as same. Assessment: Claimant reported pain with elbow extension and stated decreased symptoms with stimulation and will see Dr. in about 2 weeks. Recommendation: continue treatment to improve functional use of UE.

09-26-14: Hand Therapy Re-Evaluation dictated by MD. Diagnosis: Left UE and cubital tunnel release. Subjective: claimant reported pain 5/10 and pain with elbow extension and after prolonged elbow flexion. Claimant received injection today and has a 5lb weight restriction for work duties. Assessment: Claimant with Left UE presented with increased AROM/strength and decreased edema reported difficulty with treatment due to pain with opening containers. He has significant pain with palpation of the lateral epicondyle. He continues with a positive Tinel sign at the elbow with decreased 2 point discrimination in the ulnar nerve distribution. We will attempt another steroid injection and continued activity modification. He will benefit from continued skilled OT for improving functional use of UE. Plan: continue with treatment plan 2xweekx3weeks. F/U one month.

10-17-14: Occupational Therapy Note dictated by OT. Claimant reported arm slightly better. Assessment: claimant reported no pain in wrist, but soreness in forearm and pain with elbow ext. Claimant to see Dr. next week.

10-23-14: Office Visit: EMG and NCV dictated by MD. Electrodiagnostic Impression: This is a normal study. There are no electrophysiologic findings to suggest focal mononeuropathy, peripheral neuropathy and cervical radiculopathy based on today's study.

10-24-14: Hand Therapy Re-Evaluation dictated by MD. Diagnosis: LUE and cubital tunnel. Claimant reported 4/10 pain which increased with elbow extension. Provided claimant with wrist cock-up splint. Assessment: Claimant with Left UE and cubital tunnel presented with decreased edema and continued difficulty opening containers and lifting. He will benefit from continued skilled OT to improve functional use of UE. Continue with treatment 2x week x 3 weeks.

10-24-14: Encounters and Procedures dictated by MD. Reviewed problems: lesion of ulnar nerve, lateral epicondylitis, and glenoid labrum detachment, right. Medications: naproxen. PE: none recorded. Assessment/Plan: Claimant continues to have 4/10 pain on the lateral elbow as well as numbness and tingling in the ulnar nerve distribution. This is despite several months of conservative treatment with over 2 injections, therapy x10, splinting, and activity modification. Claimant has MRI showing lateral epicondylitis. He has failed conservative measures. Recommend lateral epicondyle debridement and cubital tunnel in situ nerve release.

10-31-14: UR performed by MD. Reason for denial: The claimant is a male who sustained an injury on xx/xx/xx when he fell off the ladder but was able to break the fall by hanging with his hands. The claimant was diagnosed with left lateral epicondylitis and left cubital tunnel syndrome. A request is made for outpatient left lateral epicondyle debridement and left in situ ulnar release. Treatments to date include medications, splinting, physical therapy, and injections. Left elbow MRI dated 8/25/14 revealed findings consistent with active lateral epicondylitis with partial thickness tearing of the common extensor tendon origin from the lateral humeral epicondyle. The medical report dated 10/23/14 states that the claimant has left elbow pain, neck pain and right shoulder pain. He denies numbness and tingling in the upper extremities. On physical examination of the left elbow, there is tenderness at the left lateral epicondyle. There is negative Tinel's over the cubital, pronator, carpal and guyon's area. There is normal sensation and normal motor sensation. EMG and NCV of the upper extremities dated 10/23/14 revealed normal findings. The most recent medical report dated 10/24/14 stated that the claimant has left elbow pain. Medication included naproxen. It was noted that the claimant continued to have 4/10 pain on the lateral elbow as well as numbness and tingling in the ulnar nerve distribution. There is despite several months of conservative treatments with over two injections, therapy, splinting and activity modification. As for the requested left lateral epicondyle debridement, although the claimant has evidence of left lateral epicondylitis, 12 months of compliance with non-operative management was not documented. Given the claimant's date of injury, the recommended 12 months of conservative treatment cannot have been provided. AS for the requested in situ ulnar nerve release, the recent physical examination findings and electrodiagnostic findings did not document clear evidence of ulnar nerve entrapment/pathology. As such, the medical necessity of this request for left lateral epicondyle debridement and left in situ ulnar nerve release has not been substantiated.

11-04-14: Hand Therapy Re-Evaluation dictated by MD. Diagnosis: LUE and cubital tunnel. Claimant reported decreased pain with wrist cock-up splint but reported continued pain with elbow extension, 4-5/10. Assessment: Claimant with left UE and cubital tunnel presented with increased strength and decreased edema, stated he was waiting for approval for surgery. STG: Claimant improved in prec. and preventative techniques: progress. LTG: Claimant reported decreased pain levels to 3/10 with light activity: progress. Claimant modified

sleep patterns to diminish ulnar nerve compression while sleeping: progress. Plan: await MD recommendation.

12-03-14: UR performed by MD. Reason for denial: On 10/24/14, the claimant reported 4/10 pain on the lateral elbow as well as numbness and tingling in the ulnar nerve distribution. It was noted that he had undergone 2 injections, physical therapy, and splinting and activity modification. A Physical examination was not performed. He was diagnosed with bilateral epicondylitis and lesion of the ulnar nerve. An appeal request was not preformed. He was diagnosed with bilateral epicondylitis and lesion of the ulnar nerve. An appeal request was made for a left lateral epicondyle debridement and left ulnar release. The ODG states that the criteria for lateral epicondylar release should be limited to sever entrapment neuropathies, as over 95 percent recover with conservative treatment. There should be evidence that at least 12 months of compliance with non-operative management had been done and there had been failure to improve with NSAIDs, elbow bands/straps, activity modifications, and physical therapy exercise programs. There should be evidence of long term failure with at least 1 type of injection. Based on the clinical information submitted for review, the claimant was noted to have failed all conservative care options. However, there was lack of documentation showing that the claimant had undergone at least 12 months of compliant with non-operative management to indicate the need for a surgical intervention. Furthermore, a recent physical examination was not documented to show that the claimant has any significant functional deficits that would indicate the need for surgical intervention. In the absence of this information, the request would not be supported by the evidence based guidelines. As such, the request is non-certified.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The claimant is not indicated for surgery on the left elbow consisting of debridement of the lateral epicondyle and in situ ulnar nerve release. The claimant currently has pain in the left elbow and forearm following an xx/xx work injury. His elbow MRI demonstrated partial thickness tearing of the common extensor origin, consistent with his clinical diagnosis of lateral epicondylitis. Although the notes reviewed reported possible cubital tunnel symptoms, his EMG/NC study was unremarkable for any nerve injury. The Official Disability Guidelines (ODG) recommends surgery for lateral epicondylitis following 12 months of conservative treatment. The vast majority of patients do not require surgery. This patient has not completed 12 months of conservative care for this injury. It is too early to consider surgery for this claimant's lateral epicondylitis, as his condition may improve with continued conservative treatment. The claimant does not require surgery for his ulnar nerve. There is no electrodiagnostic evidence of ulnar nerve entrapment at the elbow. The requested surgical procedures are not medically necessary. Therefore, after reviewing the medical records and documentation provided, the request for OP Lt Lateral Epicondyle Debridement, Lt Insitu Ulnar Nerve Release 24359 is denied.

Per ODG: Surgery for epicondylitis	**Criteria for Lateral Epicondylar Release for Chronic Lateral Epicondylalgia:** - Limit to severe entrapment neuropathies, over 95% recover with conservative treatment - 12 months of compliance with non-operative management: - Failure to improve with NSAIDs, elbow bands/straps, activity modification, and PT exercise programs to increase range of motion and strength of the musculature around the elbow. - Long-term failure with at least one type of injection, ideally with documented short-term relief from the injection. - Any of the three main surgical approaches are acceptable (open, percutaneous and arthroscopic).
Surgery for cubital tunnel syndrome (ulnar nerve entrapment)	**ODG Indications for Surgery -- Surgery for cubital tunnel syndrome:** Initial conservative treatment, requiring ALL of the following: - Exercise: Strengthening the elbow flexors/extensors isometrically and isotonically within 0-45 degrees - Activity modification: Recommend decreasing activities of repetition that may exacerbate the patient's symptoms. Protect the ulnar nerve from prolonged elbow flexion during sleep, and protect the nerve during the day by avoiding direct pressure or trauma. - Medications: Nonsteroidal anti-inflammatory drugs (NSAIDs) in an attempt to decrease inflammation around the nerve. - Pad/splint: Use an elbow pad and/or night splinting for a 3-month trial period. Consider daytime immobilization for 3 weeks if symptoms do not improve with splinting. If the symptoms do improve, continue conservative treatment for at least 6 weeks beyond the resolution of symptoms to prevent recurrence.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**